

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1L6002489</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOSAIC OF SPRINGFIELD, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>555 WEST CARPENTER</b> <b>SPRINGFIELD, IL 62702</b>		
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S9999	<p><b>Final Observations</b></p> <p><b>Statement of Licensure Violations:</b></p> <p>300.610a) 300.1210b)5) 300.1210d)6) 300.3240a)</p> <p><b>Section 300.610 Resident Care Policies</b></p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p><b>Section 300.1210 General Requirements for Nursing and Personal Care</b></p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following</p>	S9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>		

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/02/16

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S9999	<p>Continued From page 1</p> <p>procedures:</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff use safe transfer techniques for 2 of 3 residents (R2 and R3) reviewed for mechanical lift transfers in a sample of 5. This resulted in R2 and R3 sustaining fractures during an improper transfer.</p> <p>Findings include:</p>	S9999			

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S9999	<p>Continued From page 2</p> <p>1. The Minimum Data Set (MDS), dated 5/9/16, documents R3 has diagnoses of Osteoporosis and Mild Mental Retardation in part. The MDS documents R3 to be severely cognitively impaired and totally dependent on staff for all activities of daily living. The MDS documents R3 requires total assist of two staff for all transfers. On 7/13/16, the facility provided a list of residents requiring mechanical lifts for transfers. R3 is identified on a list of residents requiring mechanical lift for transfers.</p> <p>The Care Plan, dated 5/10/16, documents R3 to have self care deficits and requires to be transferred with a mechanical lift and 2 staff. R3's Kardex for CNA care documents R3 requires a mechanical lift for transfers with 2 staff assistance.</p> <p>An Episode Note, dated 7/4/16, at 7:08 PM, written by E4, Licensed Practical Nurse (LPN) documents "Nurse called stating that patient has left knee swelling after CNA's (Certified Nurse's Aides) were attempting to dress her for bed. The patient states that she accidentally bumped her left knee on the chair while moving. She denies any other trauma or falls." The treatment plan documents R3's knee appeared slightly swollen, unsure of the extent of the injury." The physician was called and an order to X-ray was given. A Situational Background Assessment Recommendation, SBAR form, dated 7/4/16, completed by E11, LPN, documents a large bruise was noted to R3's left knee measuring 8 centimeters (cm) x 4 cm, and R3 was tearful and stating her knee hurts. E11 documents "Resident stated she hit her knee on the wheelchair."</p> <p>The X-ray report, dated 7/4/16, documents under Impressions: "Horizontal fracture of the patella,</p>	S9999			

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S9999	<p>Continued From page 3</p> <p>with proximal distraction of the superior fracture fragment. This fracture appears acute. Impacted fracture of the proximal tibia, which is age indeterminate but maybe chronic. Correlate with previous radiographs."</p> <p>On 7/13/16 at 8:55 AM, E2, Director of Nurses (DON) identified E8, CNA, as being R3's CNA on 7/4/16. E2 stated after watching the tapes of activities going on in and out of R3's room on 7/4/16, E2 determined that R3 did not always have two assist to transfer. E2 stated E8 and E5 CNA were observed going into R3's room after breakfast and E4 LPN going into R3's room before lunch to do a treatment but didn't see any other incidents when staff entered R3's room to assist E8 in transferring R3. E2 identified E9 and E6 CNA's as also working on 4th floor 7/4/16. E2 stated there is a Kardex on each floor in front of the CNA documentation book that is updated daily that identifies the type of transfer each resident is to have and how many staff are to assist. E2 stated it is the policy of the facility that the mechanical lift have 2 staff present when used.</p> <p>On 7/13/16 at 11:00 AM, E4 stated E8 was R3's primary aide on 7/4/16. E4 stated R3's normal behavior is sometimes to cry but she noticed that afternoon, it was continuous. E4 stated R3 does talk but only to people she knows and trusts, those most likely to take care of her the most. E4 stated after lunch, she asked R3 if she was okay and she shook her head "no." E4 stated after they found her knee swollen, she asked E8 if she used the mechanical lift to transfer and E8 told her she lifted her and did not use the machine.</p> <p>On 7/13/16 at 11:30 AM, E5, CNA, stated that she recalled R3's incident on 7/4/16 and stated she</p>	S9999			

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S9999	<p>Continued From page 4</p> <p>helped E8 with only one transfer that day and it was after breakfast. E5 stated R3 normally cries and whines but doesn't usually complain of pain. E5 identified E9 and E6 as also working 4th floor on 7/4/16.</p> <p>On 7/13/16 at 11:35 AM, E6, CNA, stated she worked 4th floor on 7/4/16 but did not assist E8 with any transfers for R3.</p> <p>On 7/13/16 at 12:20 PM, E9, CNA, stated she worked 4th floor on 7/4/16 and did not assist E8 with any transfers for R3. E9 stated people think R3 doesn't know what's going on but she does and can talk when she wants to.</p> <p>On 7/13/16 at 1:30 PM, E8, CNA stated 7/4/16 was an average day for R3 and when asked who helped her transfer R3 throughout the day, identified only E5 helping her around 11:30 AM. E8 was asked who helped her the other times, stated she used the mechanical lift.</p> <p>On 7/13/16 at 1:58 PM, Z2, R3's Power of Attorney stated she questioned how R3 could bump her knee and sustain a fractured knee. Z2 stated she visits weekly and has seen numerous transfers where staff lift R3 into bed and has never seen a mechanical lift used. Z2 stated R3 told her at the hospital that she hit her knee during a transfer but couldn't recall what time it was and didn't want to identify the CNA for fear of getting her into trouble.</p> <p>Disciplinary reports dated 7/13/16 for R3's incident of 7/4/16 documents E8 was given a formal warning for failure to have two staff for a (mechanical lift) transfer.</p> <p>The facility's policy and procedure entitled "Safe</p>	S9999			

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S9999	<p>Continued From page 5</p> <p>lifting and movement," dated 4/2016, documents the policy is "to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents." The policy documents staff are to follow procedural guidelines for whatever type of transfer assistance is identified.</p> <p>2. Admission Sheet for R2 documents diagnoses include Osteoporosis in part.</p> <p>The MDS dated 5/26/16 documents R2 has severe cognitive impairment and is totally dependent on two staff for all transfers. The Care Plan did not document what type of transfer R2 requires. The facility's list for Mechanical lifts, provided on 7/13/16, identified R2 as requiring a mechanical lift. R2's Kardex documents she is to be a 2 person assist with mechanical lift.</p> <p>A SBAR dated 6/20/16 written by E11, LPN, documents "CNA called writer into room. Upon entering, res (resident) noted to have RT (right) foot/ankle caught in between bed frame railing/mattress area. Mattress lifted by staff + res foot freed from railing/mattress area. Head to Toe assessment completed. Rt ankle swollen c (with) reddish purple discoloration. Res also had slight grimacing". The SBAR documents an X-ray was done at 2240 (10:40 PM).</p> <p>An incident report completed by E11, dated 6/20/16 at 1855 (6:55 PM) documents "Res (R) (right) foot R ankle was caught in bed frame railing/mattress area. CNA notified Nurse." The CNA was identified as E10. The report documents R2's ankle to be swollen with some discoloration (Purple/reddish.) The incident investigation worksheet dated 6/20/16 documents</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>that the only witness was E10 and R2 "did not fall." The Investigation documents E10 stated R2 was shaking/having anxiety during care and transfers resulting in R foot getting stuck in railing mattress area.</p> <p>The X-ray report dated 6/20/16 documents a "Medial and lateral malleolus fracture which are essentially non-displaced."</p> <p>E2 stated on 7/13/16, at 3:30 PM, that E10 stated did not use a mechanical lift as required by R2. The discipline report documents E10 stated she lifted R2 by herself and did not use a gait belt. As the result, R2 sustained a fracture during transfer.</p> <p>On 7/13/16 at 11:20 AM, R2 was in bed. Her bed had a head board and foot board but no railings.</p> <p>(B)</p>	S9999			